Sunderland City Council

# Adult Services Prevention Strategy

2023–2026

# Introduction

Local authorities have a duty under the Care Act 2014 to provide services that will contribute towards preventing, reducing or delaying the need for Care and Support/Support.

As part of our strategy for achieving the council's vision and meeting the requirements of the Care Act, Adult Services has committed to delivering a relentless focus on a preventative approach using existing and developing new community assets, whilst embedding a culture that embraces the positive outcomes that technology can bring.

CQC also recognises the importance of moving from a reactive to a preventative care model in order to ensure people are enabled to have longer, more fulfilling and independent lives.

The promotion of wellbeing and independence is central to the city's ambition to enable people to live healthier, independent lives for longer, remaining in their own home and actively engaging in their community.

We will continue to work in partnership with other organisations and communities to empower our residents to retain their independence and consider residents who may or may not have eligible social care needs and their carers, in the continuous development of a local approach to prevention.

In addition to Living and Ageing Well, Adult Social Care Strategy, 2022–2024, this document sets out the progress made towards embedding preventative approaches in our ways of working and how we will accelerate this in the next two years.


making it real

# Our approach to prevention

This local approach is designed to reflect a three-stage approach; to prevent, to delay and to minimise.

## Preventing the need for care and support

The service works in partnership with the wider council and its partners in health, housing, social care and the voluntary sector to deliver a range of universal services that provide good quality advice and guidance and promote the maintenance of health and wellbeing, preventing the necessity to access formal services.

Public Health colleagues commission and deliver a wide range of services that cover many areas for sexual health, alcohol and drug misuse through to NHS checks, mental health and wellbeing, and public awareness campaigns for diseases such as cancer, heart disease and stroke.All of which, have a direct link to preventing, delaying or minimising the need for formal social care.

A dedicated Public Health Business Partner has been established to work directly with Adult Social Care to build on and strengthen existing ways of working such as prevention, building on community assets and working collaboratively and this role is considered an excellent way to connect both service areas.

In the community, the majority of NHS patient interactions are delivered in primary care, through general practice, dentistry, optometry and community pharmacy, all of which play a vital role in supporting people to retain and maintain their independence and prevent the need for formal Adult Social Care support.

Primary care maintains good working relationships with social care and the VCSE sector both at an operational and strategic level.

Sunderland Information Point is an online resource for children and young people, families of children with special educational needs and adults. Information is continually maintained and users are able to search for services, create their own list of resources and make contact with the council to ask for advice or support.

In 2023, we conducted a review of the content of the council's social care web pages, ensuring the links to Sunderland Information Point, providing charging information and enabling on line self-referral.

We have also sought support from an independent body to help ensure we are maximising the opportunities for residents to engage with our information, advice and guidance offer.

In 2024, we will decommission Sunderland Information Point and implement a new interactive digital platform to support the Links for Life Model, which incorporates social prescribing by linking residents to

services and self-help resources, with or without the support of link workers. This digital platform will connect residents and partners, including voluntary and community sector providers, across the system to improve the health and wellbeing outcomes of our residents and it is our intention to develop its content through a co-production approach

In 2023, we delivered a range of outreach sessions to groups in our neighbourhoods and local communities promoting a range of preventative services across our offer and establishing a regular drop-in session at Sunderland's Bangladesh International Centre.

In 2024, we will seek to continue and expand this programme by connecting with the Community Digital Health Hubs across the city, funded through the UK Shared Prosperity Fund.

Through the development of our Ageing Well Ambassadors, we have created a body of local people, who act as the voice of Sunderland's older residents, informing services and investment in the city to ensure that people of all ages are able to lead fulfilling lives.

Connected to the Ageing Well Board, this group aims to achieve an age friendly city by considering work places, leisure opportunities and other local community settings and resources.

We have recognised the significant issue of falls in older people, with a higher than average hospital admission rate in Sunderland as a result. Maintaining muscle strength and balance is vital to enabling people to stay healthy and protect against the potential for falls.

The Ageing Well Board has promoted the development of a wide range of local groups and services offering regular strength and balance activities for residents of all ages and with strong support from Public Health, connected these groups to the city's Falls Coordinator, a post created by the board in 2022.

In 2023, the Falls Coordinator established the city's Multi Agency Falls Group and through this collaboration, launched Sunderland's Falls Strategy, 2023–2026.

The strategy is founded on eight principles that capture partnership working, training and awareness raising, deployment of technology, evidenced based decision making and development of positive customer journeys.

We have commissioned the Sunderland and County Durham Royal Society for the Blind to provide support to people experiencing visual impairment and sight loss. Through this arrangement, we ensure that residents can access support groups and vital information, assessment of need leading to the provision of specialist equipment and programmes of specialist mobility training.

In 2024, we will engage in a review of the support provided to people experiencing visual and hearing loss or impairment, making a commitment to ensuring that we take a co-production approach to both the review and the development of our outcomes.

We have worked with Age UK to develop its Front Door Service, that offers a single point of contact for older people offering low-level tailored support to enable them to continue living safely and independently in their community.

The service offers support groups, information and advice, advocacy and through its living well link workers and Keeping In Touch service, aims to connect people with their communities and guard against social isolation.


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We recognise the importance of maintaining a safe and habitable home environment and some of the challenges associated with this.

Sunderland's Home Improvement Agency has commissioned a handyperson's service through a local charitable organisation, Community Sustainability Services that offers small repairs and home maintenance tasks such as fitting grab rails, changing bulbs or repairing guttering for a nominal fee. Sunderland Recovery College recognises the importance of maintaining good mental health.

The college operates through a peer led approach and offers courses free of charge, covering a wide range of subjects designed to support people to learn the skills and knowledge they need to facilitate a good mental health recovery journey and guard against illness.

Learning opportunities are face to face and on-line and the organisation places high value on the offer of a safe environment created by peer led support.

The Housing Service in the council has supported the growth of housing in the city to support vulnerable people, older people and young people to stay in their homes or find suitable housing if this was required.

They have worked with other partners in the city to enable people to access and maintain a good quality home by connecting them to services across health, education, training and employment and provide the support they need to live happy, independent lives; especially those facing barriers and who are less able to help themselves.

We have worked with Homeshare UK to understand the benefits of this model in preventing loneliness and the need for formal support as a consequence of someone not being able to live in their own home without practical support and social interaction.

We recognise the positive role the Homeshare model can have on a person's wellbeing: it is one of the options available at our Adult Social Care Front Door service.

Social Prescribing continues to develop in Sunderland. Led by the Sunderland GP Alliance and supported by the council, social prescribing aims to empower people to take control of their health and wellbeing and facilitate this by connecting people with diverse community groups and opportunities to explore and develop a support network that focuses on the things that matter most to the individual.

We provide grant funding to Washington Mind who lead a partnership with Sunderland Mind and Sunderland Headlight to provide a My Life Support Project. The project promotes practical help with day to day living that people with mental health problems often need in order to stay well and live a full life. This includes the additional social support that they are likely to need in connection with their mental health problem; support that can be crucial in keeping people in the community. The project provides people with information, advice, support and guidance which are essential factors in supporting people's mental health and wellbeing.

# Reducing the need for care and support

We have worked with our partners to create an offer of targeted interventions, designed to support key groups of people who are more likely to develop care and support needs, that may help to slow down deterioration of an existing problem or prevent new problems from arising.

We have worked with housing and social care partners to develop new and bespoke accommodation care and support solutions for people with disabilities, mental health and complex care needs.

The person centred approach taken when considering new build developments and renovations has meant that people who have spent a large amount of time in long stay hospitals or endured multiple different care and accommodation solutions with different providers have now found a home for life and a care and support team that has been built around them as individuals.

The new developments that have been built have also been provided with digitally enabled care solutions as part of our approach to promoting independence and reducing the need for care and support.

The social care providers supporting people in their own homes aim to improve the quality of life of the person through implementing the principles of Positive Behaviour Support and ensuring care is delivered in the least restrictive way.

Sunderland Care and Support are commissioned to deliver the city's Home Improvement Agency. Working in partnership with our Community Therapy Service, the agency delivered 788 Disabled Facilities Grants in 2022–23 to create accessible homes for children and adults in the city.

In addition, the service offers housing assistance advice and loans to maintain the standard of homes, oversees the city's handyperson's service and offers energy efficiency advice to keep people warm and safe and reduce fuel poverty.

The Community Equipment Service offers a seven-day service to deliver, fit, demonstrate, repair and maintain essential items of equipment to facilitate safety and independence in activities of daily living. The service provided 41,453 items of equipment in 2022–23 to 10,153 customers and in addition, launched its Community Equipment Services Telephony App.

This app reaches out via an automated telephone call to customers who have been provided with a piece of equipment regularly during the lifetime of the loan, to check that the equipment is meeting their need and establish whether any further problems have arisen.

Customers who indicate a requirement for some level of additional support are contacted by a care coordinator from Sunderland Care and Support's Single Point of Contact and assisted to navigate to the team, service or point of information that will help them.

We have continued to develop our understanding of technology enabled care, employing Digital Occupational Therapists and opening Sunderland's Smart House in 2023. The Smart House blends environmental and digital design in a domestic property for the purpose of demonstrating the capability of smart technology in the

facilitation of independence. In 2024, we will use the Smart House to accelerate health and social care practitioner's understanding of assistive technology whilst also developing the Virtual Smart House, which seeks to recreate the Smart House in an on line platform that facilitates continuous training and awareness raising for our colleagues, our customers and our partners.

In 2023 therapists and Social Workers, worked in partnership with Sunderland Care and Support's Technology Enabled Care Team to develop personalised care plans that utilise devices matched to individual circumstances and oversee an initial project that explored the potential to use sensor-based technology to support home monitoring solutions.

In 2024, we will further develop our understanding of remote monitoring solutions, assisted by the council's Smart City programme. We will deploy sensors linked to the city's newly established Lorowan network to deliver home monitoring whilst also tackling the issue of affordability that is associated with Wi-Fi based systems.

We will also continue to develop our Telecare service that currently supports over four thousand people living in our community. Delivered through a partnership between the council and Sunderland Care and Support, the Telecare service will complete its transition to a fully digital offer well before the target completion date of 2025.

As part of our digital strategy, we will explore the potential to introduce new tech based means of providing support that is both proactive and reactive through the introduction of devices that assist in medication management, the development of positive routines and the reduction of social isolation.

We will complete a project implemented in 2023, that deploys Alexa Skills through a fleet of centrally managed devices, connected to a team of support officers.

In 2024, the Falls Coordinator will roll out a model for improving the management of falls in our city's care homes. Having refined this way of working in partnership with the community bed based, intermediate care service at Farmborough Court, the model includes a baselining exercise, a programme of training and awareness raising, the implementation of a multifactorial falls assessment and a mechanism for reviewing and learning from critical incidents.

We will also develop an on line falls assessment tool that produces personalised outcomes for users, pointing them in the direction of the support required from the relevant Sunderland based services.

In 2022–23 our Independent Living Officers successfully completed 2,031 appointments with people who benefitted from the provision of equipment to assist with daily living and provided information and advice in respect of other services that might support their continued independence, while our community Occupational Therapy teams completed 2,751 assessments with children and adults who are experiencing the impact of disability and long term health conditions ensuring their safety and successful community living.

The city's wheelchair service is provided in partnership between our adult services, the Regional Engineering Service and Sunderland Care and Support.

We have introduced personal wheelchair budgets in the city and in 2022–23 we completed 1,453

assessments for people in the city and introduced a telephony app that maintains contact with wheelchair users in the city, enabling the proactive identifications of customers who need a review of their equipment.

We will continue to work closely with our Carer's Centre, who are commissioned to support us in the delivery of carers assessments. In 2022–23, we completed 6,637 carers assessments, either independently or combined with an assessment of the cared for.

In 2022, we produced our five-year strategy to support carers to live happy, healthy lives. The priorities set out in the strategy are designed to ensure carers feel recognised, listened to and respected, able to access good information, kept up to date with new information and in receipt of the right services to support them in their caring role. The action plan set out in the strategy will be delivered by an implementation group made up of key stakeholder and will be overseen by our Ageing Well Board.


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# Delaying the need for care and support

In 2021, we created the Therapy Care Home Team in partnership with the local Primary Care Network, through its Additional Roles Reimbursement Scheme (ARRS). Comprising of Occupational Therapists, Physiotherapists and Rehabilitation Assistants, the team work with residents of registered care homes in the city to promote mobility and independence.

With an average of 82% of customers going on to receive a rehabilitative intervention following referral, the team works closely with care teams, the Falls Coordinator, Older Person's Specialist Nurses, Social Workers, Podiatrists and Dieticians to achieve positive outcomes for care home residents.

Admission to hospital or a bed-based intermediate care service arises as a result of injury or illness and signals a traumatic life event. Often people need some additional support to help them in their recovery and the development of the Hospital Discharge Grant offers the opportunity to access up to £1,000 to provide the kind of assistance that the person feels is important to them for up to four weeks.

This personalised approach is intended to speed up the person's ability to leave hospital, successfully avoiding the potential for deconditioning once their medical crisis is stabilised.

We have worked closely with partners in South Tyneside and Sunderland Foundation Trust to support the implementation of the Transfer of Care Hub, facilitating timely and supported discharge for patients leaving hospital who require support to regain their independence.

Through our partnership arrangements, we have established an intermediate care community bed-based offer to provide rehabilitation, reablement and convalescence for adults who are recovering from the onset of an acute illness or exacerbation of a long term condition.

Services primarily offer support in respect of issues arising from physical health conditions or dementia but do not exclude customers who may also have learning disabilities or mental health conditions.

The council's Community Rehabilitation Team comprise of Occupational Therapists, Physiotherapists and Rehabilitation Assistants, and offer rehabilitation and oversight of safe transition home for people who have accessed bed-based support.

The city's Reablement Service is provided by Sunderland Care and Support and offers home based support to meet the goals identified by the referrer and the customer that will achieve or maintain the customer's independence.

The team works in partnership with South Tyneside and Sunderland Foundation Trust's Recovery at Home Service who deliver crisis response and home-based intermediate care, and the council's Community Rehabilitation Team.

Our Reablement Apartments provide the opportunity for a temporary stay in an extra care apartment in the city.

This service is designed to support customers who are awaiting structural adaptation to their home, who may be considering a move into extra care or permanent care or where there is an environmental issue affecting their

ability to return to their own home that will be resolved within a short space of time.

A stay in a reablement apartment will be complimented by the provision of support from the Reablement Service.

In 2022, we implemented a telephony app that reaches out to customers who have left an intermediate care service and establishes any outstanding needs or arising difficulties.

The Single Point of Contact are responsible for contacting customers who indicate they may require some further assistance, and help them to navigate to the right place for support.

Our commissioning arrangements are inclusive of services that delay the need for more intensive and costly support. We commission day services and short break services that support carers to have a break from their caring role.

We have developed a new approach to home care called the Keeping Well Service which will consist of a range of different service offers with specific service requirements and eligibility criteria to ensure people are supported to access the right support to meet their care and support needs.

The Keeping Well Service will also be inclusive of a reabling approach to ensure people's independence is fully maximised, enabling them to live longer in their own homes.

# Redevelopment of the front door to Adult Services

Central to our Prevention Strategy is the implementation of our new front door to Adult Services in 2024.

This initiative seeks to deliver a strength-based approach to supporting customers who are seeking help to enable them to continue living independent and fulfilling lives whilst also managing the impact of disability, frailty or a long term health condition.

Delivered through a partnership between the council's Customer Services Network, Sunderland Care and Support and Adult Services, the Front Door will bring together Social Workers, Occupational Therapists, Assessment and Review Officers, Physiotherapists, Rehabilitation Assistants, Care Coordinators and Call Handlers to connect customers with the support that best meets their needs.

As part of its ongoing development, we will integrate the role of the Single Point of Contact and the support offer from partners in the voluntary sector to develop an holistic approach to new enquiries that harnesses the opportunity to prevent, reduce or delay.

Using a three-conversation approach, the Front Door will offer an initial conversation where we listen to the things that are important to the person. Where appropriate, the team will work intensively with someone in crisis, stabilising the situation and keeping people safe.

The team will ensure that where necessary, the customer is then able to have their third conversation with the most appropriate team or person to help them establish what good looks like in their life and how to achieve this. This third conversation might not always be best provided by a social care provider but it should form the key to preventing further crisis from arising.

## Preventing

- Links for life and connection to social prescribing and VCS
- Community Outreach Programme
- Falls Awareness, Strength and Balance Programme
- Home Improvement Agency - Handy person Service, Home
- Renovation Grants, Home Safety Grants
- Commissioned services to support sensory loss
- Sunderland Recovery College

## Adult Services Front Door Offer

- 3 Conversations model - strengths based approach
- Gathering key information to 'Listen and connect'
- Confirming consent/preferred communication method and supporting customer expectation and outcomes
- Case finding through telephony apps
- Stabilising crisis situations
- End of life support
- Blue Badge
- Self assessment for social work and equipment
- Referrals to Home Improvement Agency
- Identifying multi-agency working at point of referral, initiating collaborative MDT working
- Link with safeguarding (s42) and promoting and embedding Wellbeing Principle of Care Act (2014)
- Link with commissioning to help market shaping and development

## Reducing

- Provision of equipment and adaptations
- Technology enabled care
- Falls assessment
- Falls management in care homes
- Wheelchair services
- Carer's centre

## Delaying

- Therapy Care Home Team
- Transfer of Care Hub
- Community Rehab Team
- Reablement
- Community Bed Based Intermediate Care


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# Our pledges for achieving the Prevention Strategy

Moving forward, the following pledges are central to our approach to prevention

Teams and services will work with people in a way that harnesses the strengths and resources of the individual so that they become enablers to achieving safe, successful community living

Care plans and services will be developed through a process of co-production, ensuring that outcomes reflect what good looks like to all key stakeholders

The needs of carers will be central to the local approach to prevention

We will use evidence, data and the views of stakeholders to influence the continuous development of the local approach

We will work collaboratively with our Public Health colleagues to strengthen our understanding of the social and commercial determinants of health and the links between these, prevention, health and wellbeing

We will work with customers, carers and partners to promote innovation and continuous learning

We will work with our partners to implement the outcomes of the commissioned review of out of hospital pathways

We will embed and refine the Adult Services Front Door

We will promote Links for Life and social prescribing

We will promote the Falls Strategy, driving forward its associated action plan

We will use our Smart House to promote technology enabled care

We will continue to support the work of the Acute and Community Therapy Services partnership group to ensure that rehabilitation is at the heart of our offer

We will embed our new operating model for Adult Social Care, promoting the three conversation approach that starts in the Front Door across our whole structure

We will promote the use of Direct Payments and Personal Wheelchair Budgets

We will embed our Carer's Strategy and ensure that we can identify carers and connect them with the support they need

We will proactively engage with the social care and housing markets to generate and share ideas in relation to our prevention agenda

We will understand and access the offer from the voluntary, community and social enterprise sector from a universal and support services perspective

# Conclusion

We are committed to facilitating safe and independent living, for Sunderland residents who are experiencing the challenges of living with a disability, long-term health condition or the affects of old age.

Central to that commitment is an ambition to prevent, reduce or delay the requirement for entry into formal care and support services, and an intention to work in partnership with the person and our colleagues in health, care and voluntary services to achieve this.

We have developed the foundations of this approach and will go on to embed and refine this way of working through the delivery of a series of pledges that we will achieve by 2026.

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